

Antibiotic prophylaxis for cold coagulation of the cervix

Whether or not sultrin is useful in the context referred to by White *et al.*,¹ the results as presented do not provide the answer. There was no blind assessment, the 110 intended patients were reduced to 89 in the analysis and, if the randomisation was valid, most of the 21 missing must have come from the groups not given sultrin. It is unlikely that they all bled to death but still scarcely appropriate to use "exact probability" calculations which leave them entirely out.

What is clear, from those patients whose outcomes are reported, is that almost one in five bled for more than a week and over half had discharge for more than 2 weeks. There is more to "cost" than the proportion of the antibiotic budget. One might start by asking whether all of the surgery was necessary. Five year observation without intervention has shown that regression is more common than progression, rapid change is rare and severity of dyskaryosis is more important than the presence or absence of papilloma virus.² Despite some opinions that "the epidemiological evidence is overwhelming",³ one also finds "but it has never been shown that women with warts have an increased risk of developing cervical cancer"⁴ and "unequivocal epidemiological support for a causal relationship (for cancer) to the presence of such "high risk" HPV types have not yet been presented".⁵

Finally, the logic of including a one week course of metronidazole in the comparison is not entirely clear. If it was because a quarter of the patients had "bacterial vaginosis" one might have expected some discussion of this in the analysis. If it was used in the hope of reducing post-operative infection then it was probably inappropriate. There is abundant evidence that antibiotic in the tissues at the time of surgery can reduce the infection rate, whilst antibiotic given post-operatively is more or less useless for this purpose.^{6,7} A single 2 g dose given an hour before surgery should provide the levels needed to test whether metronidazole prophylaxis might be helpful in these patients.⁸

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- 3 Chuang T-Y. Condylomata acuminata (Genital Warts). An epidemiological view. *J Am Acad Dermatol* 1987;16:376-84.
- 4 Oriel JD. Human papillomaviruses and genital neoplasia: the changing scene. *Int J STD & AIDS* 1990;1:7-9.
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- 8 Woodcock KR. Treatment of trichomonal vaginitis with a single oral dose of metronidazole. *Br J Vener Dis* 1972;48:65-8.

Safe sex and women

Drs Sherr and Strong in their article *Safe Sex and Women*¹ have used the terms "safer sex" and "safe sex" interchangeably, respectively three and 28 times. These terms certainly do not mean the same thing. I would also like to suggest that there is no such thing as "safe sex", and these words, in the context in which they have been used, can be misleading.

In the context of prevention of HIV infection, health education is about changing sexual behaviour and adopting safer sex practices. Hence the use of the term "safer sex" is more appropriate and deserves to be universally adopted.

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- 1 Sherr L, Strong C. Safe sex and women. *Genitourin Med* 1992;68:32-5.